



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE  
**BOARD OF DENTISTRY AND DENTAL HYGIENE**

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: [DPR.DELAWARE.GOV](http://DPR.DELAWARE.GOV)  
EMAIL: [customerservice.dpr@state.de.us](mailto:customerservice.dpr@state.de.us)

**APPLICATION FOR RESTRICTED PERMIT I**  
**Conscious Sedation Induced by Parenteral, Enteral or Rectal Routes**  
**INSTRUCTION SHEET**

**What Does a Restricted Permit I Allow?**

A Restricted Permit I allows you to induce only **conscious sedation** by parenteral, enteral, or rectal routes at a specific location. (This does not preclude the usual and customary pre-operative oral sedation.)

If you hold a Restricted Permit I, **you are not allowed to induce:**

- deep sedation
- general anesthesia

Before applying for a permit for sedation or anesthesia, it is imperative for you to thoroughly review Section 7.0 of the [Rules and Regulations](#) of the Delaware Board of Dentistry and Dental Hygiene. The Board's rules define conscious sedation, deep sedation and general anesthesia using definitions adapted from the American Dental Association.

If you are applying for a Restricted Permit I, you must fully understand the difference between conscious sedation and deep sedation. The educational requirements for deep sedation and general anesthesia are much more stringent than for conscious sedation. This distinction is important both from the standpoint of this permit application and from the standpoint of clinical practice:

A patient who is given an intravenous drug is in a state of **deep sedation** if he or she loses either the ability to respond rationally to command or any protective reflexes at any time during the procedure.

**Inspection Requirement**

The Anesthesia Advisory Committee (AAC) must complete a satisfactory inspection of your office before a permit is issued. The AAC reviews applications and performs inspections under the Board's direction.

- Submit a separate application for **each location** where you will administer sedation or anesthesia.
- Submit your application for a permit only when the location is **ready** for AAC inspection.

**Requirements for Permit Applications**

It is your responsibility to arrange for the Board to receive all documents listed below. If clarification is needed, the Board may request more information or documents.

- ☐ Submit completed, signed and notarized [Application for Restricted Permit I](#).
- ☐ Enclose the non-refundable [processing fee](#) by check or money order made payable to the "State of Delaware."
- ☐ Submit proof – such as a letter or transcript from a school or a completion certificate – showing that you have satisfied both of the following requirements for conscious sedation induced by parenteral, enteral or rectal routes:
  - Minimum of 60 hours of instruction in this technique
  - Management of a minimum of 20 patients in this technique.
- ☐ Enclose a copy of your current cardiopulmonary resuscitation (CPR) certification card.

- ☐ If you have never been issued a U.S. Social Security Number (SSN), submit a [Request for Exemption from Social Security Number Requirement](#).

The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

If approved, your Restricted Permit I will be mailed to the address on your Dentist license. You may change the mailing address for your Dentist license and permit(s) online at [Update Contact Information](#).



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE  
**BOARD OF DENTISTRY AND DENTAL HYGIENE**

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: [DPR.DELAWARE.GOV](http://DPR.DELAWARE.GOV)  
EMAIL: [customerservice.dpr@state.de.us](mailto:customerservice.dpr@state.de.us)

**APPLICATION FOR RESTRICTED PERMIT I**  
**Conscious Sedation Induced by Parenteral, Enteral or Rectal Routes**

**IDENTIFYING AND CONTACT INFORMATION**

1. Name: \_\_\_\_\_  
Last/Family Name First Middle Maiden
2. Other Name(s) Used: \_\_\_\_\_ ☐ None
3. Date of Birth (month/day/year): \_\_\_\_\_ Gender: Male ☐ Female ☐
4. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ If yes, enter your SSN: \_\_\_\_\_  
If no, you must file a [Request for Exemption from Social Security Number Requirement](#).
5. Delaware Dentist License Number: **G1** - \_\_\_\_\_ An active Delaware Dentist license is required. If approved, your Restricted Permit I will be mailed to the address on your Dentist license. You may change the mailing address for your Dentist license and permit(s) online at [Update Contact Information](#).
6. Phone: \_\_\_\_\_ Email: \_\_\_\_\_ ☐ None  
Daytime Home

**INFORMATION ABOUT LOCATION WHERE SEDATION ADMINISTERED**

7. Enter the following information about the **physical location** of office where sedation will be administered:  
Office Address: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip
- A Restricted Permit I is limited to one office location. If you have more than one office, submit a separate application for each location.**
8. Is the office properly equipped for the administration of conscious sedation? Yes ☐ No ☐
9. Is the office properly staffed with a supervised team of auxiliary personnel capable of reasonably handling procedures, problems and emergencies related to conscious sedation? Yes ☐ No ☐
10. Does the office have emergency drugs and equipment on-hand capable of treating:
- |                              |  |   |  |
|------------------------------|--|---|--|
| Hypotension and bradycardia? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Narcotic-induced respiratory depression (e.g., narcotic antagonists)? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Allergy or bronchospasm?     | Yes <input type="checkbox"/> No <input type="checkbox"/> | Angina pectoris?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Seizures?                    | Yes <input type="checkbox"/> No <input type="checkbox"/> | Adrenal insufficiency (e.g. steroids)?                                | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Nausea?                      | Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |

11. Does the office have the equipment necessary to provide artificial respiration and assist in airway maintenance?

Yes ☐ No ☐ **If yes, list equipment:**

---

---

---

12. Does the office have the equipment necessary to establish an intravenous infusion and to inject medications?

Yes ☐ No ☐ **If yes, list equipment:**

---

---

---

13. Is the office ready for inspection by the Anesthesia Advisory Committee? Yes ☐ No ☐ **If no, STOP. Do NOT submit this application until your office is ready for inspection.**

### QUALIFICATIONS

14. Enter the following information about instruction you have received in inducing conscious sedation by parenteral, enteral or rectal routes:

INSTITUTION NAME	COMPLETION DATE	HOURS COMPLETED

**Submit documentation verifying that you have 60 hours of instruction.**

15. Have you managed at least 20 patients in this technique? Yes ☐ No ☐

**Submit documentation verifying that you have managed 20 patients in this technique.**

16. Are you currently certified in cardiopulmonary resuscitation as documented by the American Heart Association or the American Red Cross? Yes ☐ No ☐

**Enclose a copy of your current cardiopulmonary resuscitation (CPR) certification card with this application.**

### DISCLOSURES AND DUTY TO REPORT

17. Have you engaged in the illegal use of controlled dangerous substances within the past two years? Yes ☐ No ☐ If yes, continue to Question 18. If no, skip to Question 19.

18. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?

Yes ☐ No ☐ **If yes, explain fully:** \_\_\_\_\_  
\_\_\_\_\_

19. Have you ever been denied a DEA (Narcotic) registration number? Yes ☐ No ☐ Current DEA # \_\_\_\_\_  
**If yes, submit a letter explaining fully.**

20. Have you ever had your professional license subject to disciplinary action (including but not limited to consent agreements, fines, probation, suspension or revocation)? Yes ☐ No ☐ **If yes, submit an official Board order or other documents describing the disciplinary action.**

21. Has any jurisdiction rejected your application or revoked your professional license? Yes ☐ No ☐ **If yes, submit a letter explaining fully. Include copies of all official documents or Board orders.**

22. Have you had any malpractice actions brought against you in the past five years? Yes ☐ No ☐ **If yes, submit a list of all such actions. Include dates, disposition and amount of awards or settlements, if any.**
23. Are any complaints currently pending against you? Yes ☐ No ☐ **If yes, submit a letter explaining fully. Include copies of all official documents or Board orders.**
24. To obtain a permit in Delaware, you must certify that you understand that you have a **mandatory** obligation to report to the Board within 30 days any mortality or other incident occurring in your dental facility that results in temporary or permanent physical or mental injury requiring hospitalization of a patient during, or as a direct result of, conscious sedation, deep sedation or general anesthesia.

I certify that I have read and understand Section 7.5 of the [Rules and Regulations](#) listed above, and that I understand my *duty to report* adverse occurrences. Yes ☐ No ☐

**To ensure consideration of your permit application, the Board office must receive all of these items:**

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

**Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-6 weeks to receive your permit.**

### **AFFIDAVIT**

I hereby apply to be considered for a Sedation/Anesthesia Restricted Permit I by the Board of Dentistry and Dental Hygiene under the standards, qualifications and procedures established under Title 24, Chapter 11, of the *Delaware Code*. I have read the State statute governing the practice of Dentistry and Dental Hygiene in Delaware. I have also received and read the Board's Rules and Regulations regarding anesthesia in Delaware. I understand that the Board may require evidence additional to the material herein.

I hereby swear or affirm that the information contained in this application is correct and I understand that any intentionally fraudulent information will be reported to the Attorney General.

**APPLICANT SIGNATURE:** \_\_\_\_\_ Date: \_\_\_\_\_

County of \_\_\_\_\_ State of \_\_\_\_\_

Sworn or affirmed before me a Notary Public this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_.

Notary Signature: \_\_\_\_\_

SEAL

My commission expires on \_\_\_\_\_

***APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED FEE WILL BE REJECTED.***